TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Bobby C. Erwin, D.C.

Respondent Name
Great Midwest Insurance Company

MFDR Tracking Number
M4-15-3301-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have no EOB's regarding this bill … [the insurance carrier] stated they never received this bill. I have attached my proof when it was submitted …"

Amount in Dispute: $865.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on June 16, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2014	Designated Doctor Examination	$865.00	$850.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for completing a medical bill.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submission of medical bills.
4. 28 Texas Administrative Code §133.240 sets out the procedures for payment and denial of medical bills.
5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: No explanations of benefits were included with this dispute.

Issues

1. Were the services in question denied in accordance with 28 Texas Administrative Code §133.240?
2. What is the maximum allowable reimbursement (MAR) for the services in question?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor states in their position statement that they have not received an explanation of benefits for the services in question. The submitted documentation supports that the requestor submitted a medical bill in accordance with 28 Texas Administrative Codes §§133.10 and 133.20.

   28 Texas Administrative Code §133.240 (a) states,

   > An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

   Review of the submitted documentation does not support that the insurance carrier took final action on the submitted medical bill in accordance with 28 Texas Administrative Code §133.240. Therefore, the services in question will be reviewed according to applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.204 (j)(2)(A) states, "If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier 'NM' shall be added."

   Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (k),

   > The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

   The submitted documentation indicates that the Designated Doctor performed an examination to determine the injured employee's ability to return to work. Therefore, the correct MAR for this examination is $500.00.

   Per 28 Texas Administrative Code §134.204 (l), "The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports)". Therefore, the filing of the DWC-073 is not payable when provided in conjunction with a Designated Doctor Examination performed according to 28 Texas Administrative Code §134.204 (i).

3. The total MAR for the services in question is $850.00. The insurance carrier paid $0.00. A reimbursement of $850.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $850.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $850.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	November 3, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.